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USAF Public Health
Career Field News

Volume 1 Issue 26 **December 1997**

Your USAF Medical Service - Where are going? What are we doing? How are we doing?

The following December ***Air Force Policy Letter*** is forwarded for your information.

It's essential that every Public Health airman understand and do our part to support our USAF medical service strategy and goals.

Equally important, we must be ready and willing to explain these things to our customers and our fellow airmen.

We cannot criticize, improve, advocate, advertise, or support a strategy we aren't fully aware of. This article can help all of us in that endeavor.

The Public Health contribution to our medical service strategy is broad and impressive. I know you are heavily engaged in the traditional disease prevention tasks at every main operating base around the world and as members of our deployed global laydown teams, air expeditionary forces, air-transportable hospitals, and multiple non-standard UTCs and deployed medical teams. I salute the many hours you invest in maintaining your patient decontamination teams in readiness - a huge manpower investment. I also salute your support of the newer efforts of occupational health surveillance via the PHA, pre and post deployment health screening, immunization strategy and clinic management, epidemiological data analysis support at TRICARE regions and MTFs, evolving hospital employee health and infection control regulation compliance, and your direct manpower support in health and wellness centers. I know you've helped with new suicide data reporting systems and with the evolving PHCS, MITS, ASIMS, and theater epi reporting mechanisms and software. I know many of you serve extra duty as First Sergeants, and Group and Squadron Superintendents, where you continue to the care for those who care for our Wings.

We can expect our role, and our skills set, to change as our medical service and Air Force change. Wherever this leads us, I continue to see your work as essential to air power through airman maintenance.

Mac

Air Force Policy Letter, December 1997

(dated December 05, 1997, from RONALD T. SCONYERS, Brigadier General, USAF, Director of Public Affairs)

This issue of the Policy Letter focuses on the Air Force Medical Service (AFMS). Health care has become increasingly important as both a quality-of-life and a readiness issue, particularly as the Air Force seeks to recruit the best and the brightest in a downsizing environment.

For that reason, Air Force leadership must understand the AFMS strategic initiatives that affect the health and fitness of airmen, their families and retirees.

Strengthening the Pillars of Quality Care

The AFMS uses an icon of the Greek Parthenon to illustrate its strategy, which is based on four pillars: medical readiness, deploying TRICARE, rightsizing and building healthy communities, with customer service as the capstone. These pillars allow the AFMS to effectively respond to the tectonic pressures of a shifting economy, advances in technology, increased societal expectations and changes in national medical doctrine. To be strong enough to meet these challenges, the pillars must be built on a foundation of partnership among Air Force health care professionals, line leadership and patients. Your hospital or clinic commander is your partner and can tell you how these strategic pillars are being implemented in your organization.

Re-engineering Medical Readiness

This past year has been a banner year for the AFMS' primary mission, medical readiness, as it continued to re-engineer major programs under the medical readiness pillar. Re-engineering goals include ensuring rapid response to support theater commanders, institutionalizing evacuation of the stabilized casualty and aggressively ensuring total force partnership.

The AFMS introduced new medical technologies and strategies to maintain a high level of readiness with a smaller, more mobile medical "footprint." For example, the old contingency hospitals, designed for large-scale conflicts during the Cold War era, were large, costly and immobile. In July, active-duty, Guard and Reserve personnel worked together to re-engineer the contingency hospital into the new Air Force theater hospital. Because the theater hospital is based on the modularly deployable air transportable hospital (ATH), it is more responsive to theater commanders' needs for both flexibility and larger inpatient facilities.

To support the goal of providing rapid response to theater commanders, Air Force medics participated in contingency and humanitarian operations this year in locations such as Southwest Asia, Croatia, Africa, Central and South America, and the Pacific Rim. Highlights included staffing the prototype ATH at Prince Sultan Air Base, Saudi Arabia, and a 10-bed ATH to support U.S. humanitarian operations in Haiti. In addition, the AFMS provided crucial services to deployed troops, such as stress counseling before, during and after deployments, and epidemiological surveillance and education in-theater to prevent disease.

The AFMS has achieved its second re-engineering goal of institutionalizing evacuation of the stabilized casualty. Throughout contingency and humanitarian operations, Air Force aeromedical evacuation flight crews and critical care air transport teams (CCATTs) provided in-flight care to quickly move stable and stabilized patients.

The moving of stabilized patients -- defined as airway-secured, hemorrhage-controlled, shock-controlled and fracture-stabilized -- represents a change in Department of Defense doctrine to support the reduced forward medical footprint. The CCATT, which augments routine medical flight crews with intensive care capability, provides high-quality, en route care without draining staff and equipment from theater commanders. CCATTs are operating out of Wilford Hall Medical Center at Lackland Air Force Base, Texas, and Keesler Medical Center,

at Keesler AFB, Miss. With the initiation of a certified CCATT course in October, the Air Force began training 106 teams per year at Brooks AFB, Texas.

(Comment by Mac: The CCATT course is another fine product of your USAF School of Aerospace Medicine)

The third AFMS re-engineering goal, ensuring total force partnership, continues to be realized through the implementation of the mirror force strategy. The mirror force strategic plan provides a blueprint to organize, train and equip medics as one seamless team, with no distinction between active duty, Guard or Reserve. The mirror force concept has been incorporated into all aspects of readiness efforts. All integrated product teams, conferences, training activities, operating instructions and deployable medical teams now stress active-duty and reserve component participation..

As more operational missions transfer to the Guard and Reserve in the future, mirror force will ensure one standard -- the AFMS standard.

To prepare for these combat support missions, Reserve component medical forces will be taking on some traditionally active-duty missions in the near future. For example, in the summer of 1998, the Air Force Reserve Command (AFRC) and Air National Guard (ANG) will deploy ATH units to support Operation Southern Watch at Prince Sultan AB. The Eskan Village Clinic in Riyadh, Saudi Arabia, will see similar rotations by Reserve component units in the summer of 1999. Medical readiness personnel from the AFRC and ANG will serve rotations in the Joint Task Force Southwest Asia theater planner position. These deployments clearly demonstrate mirror force in action.

What the AFMS witnessed this year was a major transition from the past. The Air Force soon will have a re-engineered, deployable medical force that is more flexible and modular to support theater commanders and is capable of supporting evacuation of the stabilized casualty.

TRICARE: Better Access, More Choices

The AFMS strategic pillar, deploying TRICARE, focuses on satisfying its customers while finding a better way of doing business in an environment of rapidly rising health care costs and the closure of DOD medical facilities. TRICARE is designed to ensure patients receive the appropriate care and procedures they require. By deploying TRICARE as part of an overall strategy, the AFMS is able to optimize quality, cost and service.

Enrollment in TRICARE Prime has been strong and well ahead of predictions. In fact, as of October, DOD had more than 2.7 million.

Prime enrollees, including more than 800,000 at Air Force medical treatment facilities (MTFs). TRICARE Prime is available in nine health services regions; contracts have been awarded in the remaining three regions where Prime will be available by spring of 1998. A survey last year of TRICARE Prime enrollees found that 80 percent rated their care good to excellent and nine out of 10 would re-enroll. Problems that patients have experienced, such as multiple co-payments for a single episode of care and the portability of Prime enrollment, will be resolved in early 1998. Customer service for Air Force beneficiaries is further enhanced through TRICARE service centers, health care information lines and self-help information.

In addition, DOD has just started the national mail order pharmacy (NMOP) program, providing eligible beneficiaries a new, convenient and inexpensive mail order service for maintenance prescriptions. The NMOP is free for active-duty military, with a $4 co-payment per prescription for active-duty family members and an $8 co-payment per prescription for retirees and their family members. Unlike many other mail order pharmacy programs, there is no deductible fee.

TRICARE addresses dental as well as medical needs. The TRICARE family member dental plan now has approximately 1 million family members of active-duty personnel enrolled. After some initial irritants with program management following a change in contract, beneficiary satisfaction has improved. The result is a high-quality, low-cost dental program for family members.

Congress directed implementation of a retiree dental plan. Benefits for more than 4.2 million eligible people who choose to enroll in this plan will begin Feb. 1, 1998.

Enrollees will pay the full premium for coverage.

While TRICARE offers many excellent services to active-duty and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)-eligible beneficiaries, its biggest failure is still the inability to include Medicare-eligible retirees. Most military beneficiaries age 65 and older were excluded from CHAMPUS approximately 30 years ago when Medicare was first established. Lawmakers assumed that Medicare, coupled with ample space-available care in military MTFs, would be sufficient to provide comprehensive care for retirees. However, continued military downsizing and an increasing retiree population decreased the availability of space-available MTF care.

Fortunately, Congress has legislated a demonstration project to give Medicare-eligible beneficiaries the same access to MTFs as retired TRICARE Prime enrollees. The Medicare demonstration will be at six sites in the continental United States and will last for three years.

While this is an important first step in providing seamless care to all beneficiaries, there are two concerns. One concern is that a limited number of Medicare-eligible beneficiaries will be allowed to enroll in the initial demonstration project, creating some dissatisfaction among others who are unable to enroll at that time. However, the value of a demonstration project is that it offers a trial period to learn lessons and improve the process before expanding the program. A second concern is following announcement of the actual demonstration sites (and they have not yet been announced), implementation will require at least six months because of extensive regulations, particularly those of the Health Care Financing Administration. Recognizing and planning for these concerns, the AFMS has taken a lead role in implementing this demonstration project and is committed to its success. In addition, the Air Force is working with DOD to explore other alternatives to improve access to care for Medicare-eligibles.

As primary care managers and other members of the health care team work to coordinate care for their patients, they have increased efficiencies to control costs and improve access to primary care. The AFMS realigned services that were less efficient in terms of scarce dollars, personnel and facilities. Inpatient services being used well below capacity are being closed or consolidated with other services. Careful evaluation of emergency services resulted in closures of those used for mostly non-urgent care. This shifts more resources to provide routine and non-urgent, acute care in more appropriate settings such as primary care clinics, allowing improved continuity of care for patients. In addition, the limited use of emergency rooms (ERs) for true emergencies results in a loss of skills proficiency for the ER staff. Therefore, local civilian ERs provide an equal or better standard of care to Air Force patients. In the long term, the greatest efficiency will be realized from an increased emphasis on preventive services, such as health and wellness centers. Disease prevention saves dollars, but, more importantly, greatly enhances the quality of life for military families.

> Rightsizing Medical Facilities and Forces

With rising health care costs and reductions in the DOD budget, the military must maintain a

health care system capable of providing high-quality medical care within the constraints of a fixed budget.

Therefore, the objective of the AFMS "rightsizing" pillar is to develop an overarching strategy that will optimize the overall force size while it ensures the right number of people with the right skills at the right place and time.

To make the transition to a rightsized environment, the AFMS applied the DOD sizing model. This model was created as a joint effort by the Army, Navy and Air Force to establish the optimum baseline for medical authorizations, so the services could still execute readiness and day-to-day overseas missions.

In addition to this baseline, the AFMS developed several assumptions instrumental in deriving the current target being programmed into the budget. The first assumption is readiness is the first priority. The second assumption is quality health care for beneficiaries must continue, with the goal of ensuring "blue suit" care for blue suiters and their families. Third, there must be a mechanism for quality graduate medical education. Finally, it was noted that health care is a process, not a place. Care delivered outside the MTF is acceptable when based upon appropriate quality, cost and service considerations.

The rightsizing strategy, although initially directed from senior leadership, has been validated through a comprehensive strategic planning process, essentially a bottom-up review and analysis. The end product is a rightsizing strategy that will change how care is

delivered in the AFMS. Programmed changes will result in fewer medical centers and hospitals. Inefficient small hospitals will convert to clinics as the AFMS moves to a prevention-based system. Inpatient care at these clinics will shift to the civilian community.

The changes in facilities and reduction of inpatient beds have also prompted a decrease in active-duty and civilian medical personnel. AFMS planners focus on making sure the decreases are made in the appropriate medical specialties while still meeting mission and peacetime requirements, and ensuring that personnel policies are as humane as possible. Military treatment facilities will determine the specialty mix required for their patient population.

One of the greatest challenges faced in these transitions is to effectively communicate rightsizing efforts to the Air Force family and other customers. Briefings and written materials are provided to the MTFs to help answer concerns and dispel confusion, and Congress is kept informed through several forums.

The process of rightsizing the medical force is expected to continue through fiscal year 2006. It integrates both planning and programming efforts and will focus on innovative approaches to health care delivery that are cost-effective, provide continuity of care for patients and solidify prevention strategies.

Building Healthy Communities - Intervention and Prevention

The global mission of the Air Force requires airmen who are fit, healthy and ready to deploy on a moment's notice. The AFMS strategic pillar to build healthy communities was designed to meet that demand as well as deliver top-quality health services for the entire Air Force community.

To build healthy lifestyles and do it in the most cost-effective manner, the Air Force is investing in capabilities that promote prevention and intervention. Put Prevention Into Practice (PPIP) is a strategy developed by the U.S. Department of Health and Human Services, which the Air Force has implemented to organize and guide the preventive medicine efforts of medical providers.

The first step in PPIP is the health enrollment assessment review (HEAR), which is conducted

with each patient as he or she enrolls in TRICARE Prime, and then is updated annually. Data from the HEAR helps to identify the health status and prevention needs of patients. This data is then reviewed and discussed between the provider and patient for clinical management and is used by major commands and the Air Staff to assure that resources are available to care for the populations assigned.

The second element of PPIP is the preventive health assessment (PHA), which in 1996 replaced the periodic physical examination program for all active-duty members. The PHA is a four-stage process that includes a prevention-oriented clinical screening, occupational examination, screening of military-unique medical requirements and counseling. The PHA will help ensure the highest rates of mission and mobility readiness by providing feedback to commanders on the health of their troops.

Downsizing and increased operations tempo continue to challenge the Air Force. The AFMS is responding with a variety of force enhancement initiatives, such as tobacco-cessation classes and individual fitness prescriptions. To support these programs, health and wellness centers (HAWCs) have been established at every Air Force installation. HAWCs are now available on 53 bases, and installation fitness program administrators are present at 70 bases. HAWCs provide "one-stop shopping" for health promotion and fitness assessment. These efforts are paying off, as data shows decreases in smoking and increases in fitness rates in the active-duty force.

Air Force leadership is concerned about the ability of its members to cope with increasing levels of stress in the face of significant increases in operations tempo and force downsizing. As a result, the Air Force established an integrated product team (IPT) to evaluate suicides among active-duty members and to develop strategies for suicide prevention and intervention.

The IPT identified numerous factors as leading causes of suicide service-wide. Chief among them were relationship difficulties, members facing adverse actions viewed as "career ending," financial difficulties, substance abuse and the perception that seeking help would have a negative impact on the individual's career. After evaluating this information, the team called in consultants from both the Air Force and public sector to develop a comprehensive approach to suicide prevention.

Since the inception of the suicide prevention IPT, the suicide rate for active-duty members has decreased by more than 35 percent. This has been largely due to strong senior leadership, awareness training for all Air Force members, training at all levels of professional military education, and the development of critical incident stress management teams at every installation. The bottom line is successful suicide prevention is self-aid and buddy care. Everyone must lead the culture shift in the way prevention services are delivered and remove the stigma of seeking help.

The Air Force established policies providing limited confidentiality protection to service members experiencing personal problems and greatly expanded the proactive role of mental health service providers.

Various helping agencies in the Air Force -- such as family services, chaplains, mental health services, substance abuse and health and wellness centers -- now work together to provide comprehensive prevention services that enhance both individual and organizational resilience. In fact, a civilian consultant hired by DOD to evaluate the military services' suicide prevention programs praised the Air Force's program as one that is "as advanced and enlightened as any I have heard of."

Commanders, first sergeants, first-line supervisors and co-workers must be aware of danger signs and encourage members to seek help. Leaders should become familiar with Air

Force Instruction (AFI) 44-154, "Suicide Prevention Education and Community Training," and AFI 44-153, "Critical Incident Stress Management."

Base helping agencies are now working closely together under an integrated delivery system, or IDS. The IDS is designed to link base helping agencies to address risk factors, reduce stress and improve the coping skills and general well-being of individuals and families in the Air Force community. Wing commanders received guidance on implementing this system for their units earlier this year. Commanders at all levels can now work closely with the various agencies to offer a more comprehensive range of prevention services, increase the protective factors and decrease the behavioral risk factors in the community.

Family advocacy is among the agencies, which has shifted its focus from intervention to prevention. Professional family advocacy outreach managers at every base are providing educational and training programs, such as courses in parenting and couples communications.

As base agencies join ranks, potential problems can be identified earlier and efforts taken more quickly to prevent tragic trends.

Quality and Customer Satisfaction

Customer satisfaction with quality care is the capstone of the AFMS strategic plan, and the AFMS vigilantly pursues a long tradition of providing quality care. Air Force medics rigorously seek out and submit to external and internal quality assurance reviews, many by the same professional organizations that measure the civilian medical industry.

Regardless of the measure, Air Force medics consistently score as well as, and in many cases better than, their civilian counterparts. In fact, Joint Commission on Accreditation of healthcare Organizations (JCAHO) survey scores indicates Air Force hospitals have outscored civilian hospitals nationwide by 5 percent during the past six years.

In addition, 17 percent of Air Force hospitals have received "accreditation with commendation," JCAHO's highest appraisal, for their outstanding services, quality patient education and staff training programs. Only 12 percent of civilian hospitals have received this same appraisal.

The Air Force is also very proud of the fact that the number of Air Force physicians who are board-certified compares favorably with the number in the civilian community (67 percent versus 66 percent). Air Force physicians also experience a much lower rate of malpractice claims than the civilian community (seven claims per 100 physicians per year for the Air Force versus 14 claims per 100 physicians per year in the civilian sector).

High marks in clinical performance are only part of the picture. The AFMS also measures itself by how satisfied customers are with the care they receive. Recent survey results show that AFMS scores are higher in customer satisfaction than those of its civilian counterparts in terms of satisfaction with access, interpersonal relationships and quality.

The AFMS is striving to increase these positive "report cards" by making sure customer satisfaction is both the focus and end result of each of its four strategic pillars.